Ancient Tenets, Contemporary Meaning

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"CONSTRAINT" is a catchword of the age of scarce resources. We readily speak of the "the constraints of our financial situation" or "the constraints imposed by the deficit." Yet catchwords, as their name suggests, catch up into a conceptual cloud many nuances and obscure more precise meanings. They are "commonplace"—words that are familiar and immediately understood, yet comprehended only shallowly and partially. If we look at "constraint" more closely, we find that it comes from the Latin *stringere,* which means "to draw tight, to bind." In this, it is like "restraint." But unlike "restraint," "constraint" shares with many other words, like "conscience" and "consent," the prefix "con"—meaning "with" or "together" and implying something shared, held in common.

Thus, I prefer to use "constraint" to describe the common bonds of values and principles that *bind together* a society or a group within a society, like a profession. Indeed, in its early English uses, "constraint" seems generally to refer to the obligations of conscience; "restraint" applies more properly to external bonds or limits. A person is constrained by a duty or responsibility; a horse is restrained by a tether or a fence.

What does this refined nicety of verbal usage have to do with the theme of this forum? From my point of view, one question to be asked is "how can the constraints of medical ethics—that is, the obligations and responsibilities of medical practice—meet the restraints of financial limits, legal restrictions, social barriers?" Some might quickly answer that medical ethics must simply reform so that its internal constraints respond to—and mirror—the external demands. Others will adamantly reject the question, saying medical ethics must stand firm against the pressures thrusting upon medicine from without. Both views are inadequate: the first simply abolishes the unique and traditional role of medicine; the second initiates conflict between social functions that must cooperate.

A proper response must carefully examine the nature and limits of the various tenets of medical ethics in view of the economic, social and legal realities. Prolonging life, preserving confidentiality, refraining from harm, promoting the patient's benefit rather than one's own or others'—each of these tenets has a long history. Each of these has meaning that derives from the social, economic and legal context of medicine's evolution. The capabilities of physicians were interpreted within the cultural and social values of successive eras. The ethics of medicine we have today reflects that past. It contains enduring values. It will move into the future by discovering how those enduring values can be realized in new social and cultural contexts.

Thus, modern medical ethics, which has developed into a unique discipline within the last decade, does more than repeat the ancient tenets. It asks how a careful examination of those tenets might reveal their contemporary meaning. Occasionally, it will reveal that some tenet has outlived its usefulness: the ancient rule that required physicians to hide from a patient any information about diagnosis and prognosis has fallen before the new rule that requires "informed consent," a rule that reflects the modern ethics of personal autonomy. More frequently, the work of medical ethics has been to reveal the limits of some enduring tenet. The imperative "prolong life" arose when the skill of stopping a hemorrhage could save a life; it must be refined when medical technology can sustain organic processes after human consciousness or human communication are irretrievably lost.

The next task of medical ethics will be to examine how the ancient tenet of dedication to the welfare of one's patient can be preserved at a time when the financial and social organization of medical care takes new forms. How does a physician remain the patient's advocate in circumstances in which the relationship may be highly impersonal, financially unprofitable, legally threatening? Should a physician's ethic of

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absolute dedication to a patient yield before a policy that rations care in particular ways? Should physicians serve as gatekeepers into the house of care? These questions arise from ancient principles as yet untested and untried in the current world. They may sound like paradoxes—problems without solution—but they are, more likely, problems still unexamined. The constraints of a physician's conscience must not be relaxed in face of social restraints, but rather refined to discover the essential values of competent, humane and responsible care in a just and orderly society.

Cut the Cost, Keep the Care

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IN POSING THE QUESTION of this forum (What should be the aim of American medicine within the constraints of today's society?), there is the supposition that somehow efforts to contain skyrocketing costs change society's expectations of the medical profession. In the view of the American Association of Retired Persons (AARP), no such change has occurred. In fact, the slogan of our nationwide health care consciousness-raising campaign is "Cut the Cost, Keep the Care." And that is not only what we expect, but what we will demand. Implicit in our goal is our belief that the medical industry cannot justify cost increases that in 1983 were 2½ times the rate of growth in other goods and services. And that was not an aberrant year. In fact, between 1967 and 1983 when the Consumer Price Index (CPI) for all items rose by 198%, the medical care component of the CPI increased by a whopping 257%!

So to cope with inflation that was putting health care out of the reach of millions of poor and uninsured Americans and bringing Medicare to the brink of bankruptcy, Congress put hospitals on an allowance. We think it likely that lawmakers will put doctors on a similar diet soon. At the same time, it is erroneous to say society will be willing to accept a reduced standard of care. The "aim of American medicine" today should be to discover new ways to provide high quality care at affordable prices.

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And, in considering new approaches, such as prospective pricing and Diagnosis Related Groups, we must ask ourselves the following questions:

- What is high quality care?
- How can quality be measured?
- How can we assure high quality care in an environment of cost cutting?

We have taken the first few steps toward trying to answer the tricky question of quality through peer review organizations. Despite the existence of PROs, we are disturbed by numerous reports of inadequate care of elderly Medicare patients since the onset of prospective payment. In their zeal to keep profits—or so-called operating margins—high, some hospitals have been discharging elderly patients prematurely. Early discharge incentives in the prospective payment system were acknowledged as the system was begun, but the eagerness with which hospitals have been showing older patients the door has been shocking. It was not too long ago that assertions by AARP and others of premature discharge problems were being dismissed as alarmist or anecdotal. We still do not have an adequate grasp of the extent of the problem, and we recognize that not all early discharges are premature or against the patient's interest. But AARP will insist upon significantly increased vigilance and evidence that the threat of premature discharge is being taken seriously. However, society cannot look to PROs to accept the total burden for quality care. Doctors, nurses, administrators and discharge planners must take their share of responsibility for the task.

While the issue of premature discharges is important in and of itself, it must also be viewed in a broader context. We